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Compulsory treatment in psychiatry

some reflections on self-determination, patient competency and professional expertise

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The law of trespass purports to effectuate the common law's regard for personal self-determination; a medically indicated, or indeed life saving, procedure performed with reasonable care may still amount to a battery unless the doctor acts with the consent of the patient.¹ The foundation of the concept of self-determination is the competency of the patient to understand the nature and quality of the proposed medical procedure. Accordingly, the right of an individual to self-determination may have to be limited where the individual is incapable of understanding the subject matter or of expressing his will. This may occur in a number of medical and social contexts including cases where patients are of particularly old or young age, where they suffer from certain painful or terminal illnesses, where they are so severely physically disabled as to be unable to express their thoughts, or where they are severely mentally ill or mentally handicapped. The law of medicine is not sufficiently comprehensive or coherent in its expression by the courts to justify a conclusive statement concerning the legal test of competency. Nevertheless one can broadly observe that the test appears to be an individual one relating to the person's capability for comprehension at a particular time and in respect of a particular decision. There do not appear to be any fixed rules governing consent which are based upon age, legal status, medical condition, diagnosis, or prognosis.²

The one notable exception to this principle is the rigid distinction based upon legal status which is drawn under the Mental Health Act 1959 between informal and compulsorily detained

psychiatric patients. The conventional legal view is that the former class of patient is entitled to the same protections under the common law as are afforded to patients in general medicine, while the latter class is not entitled to that protection and can have treatment imposed without consent.³

Legal concern for the right of self-determination of the psychiatric patient has traditionally ceased at the hospital door on the assumption that, while the law could set procedural and substantive standards in respect of compulsory admission, it could not interfere in the clinical relationship which must be established following admission. Further assumptions are that the compulsory admission process itself provides a conclusive determination of a person's competency to make treatment decisions and that the doctor possesses sufficiently scientific and objective medical knowledge to enable him to make reliable and valid choices concerning diagnosis and treatment. The authority of the psychiatric profession to administer treatment against the express wishes of detained patients has no apparent boundary based upon the nature of the treatment, its proven efficacy, its irreversible or adverse effects, or its risks.

In this article I will examine the rationale, in legal and policy terms, of the inextricable association traditionally formed between certification and incompetency. I will argue that forming categories of people in which the law automatically dispenses with the requirement of seeking consent is fraught with conceptual inconsistencies and practical difficulties. I will further

1. See eg, Devlin, *Samples of Law Making*, 1962.
2. See generally, Williams, *Euthanasia*, 41 *Medico-legal Journal* 14, 24, 1973; Rosovsky, *Consent to Treatment*, 11 *Osgood Hall L J* 103, 1973; Kennedy, *The Legal Effect of Requests by the Terminally Ill and Aged Not to Receive Further Treatment from Doctors*, 1976 *Crim L Rev* 217; Skegg, *Consent to Medical Procedures on Minors*, 36 *Mod L Rev* 370, 1973; Gostin, *The Merger of Incompetency and Certification: The Illustration of Unauthorised Medical Treatment in the Psychiatric Context*, 2 *Internat J of Law and Psychiatry* 127, 1979, pp 137-40.
3. This article is based upon the assumption that compulsory admission under s26 of the Mental Health Act 1959 does authorise compulsory treatment. This conventional view is accepted by a number of official, medical and legal commentators. See HM Govt, *Review of the Mental Health Act 1959*, Cmnd 7320 (1978); *The Report of the Committee on Hospital Complaints Procedure* paras 7.34-35, 1973; Medical Defence Union, *Consent to Treatment* 1972; Clarke, *The COHSE Report on the Management of Violent Patients: Counsel's Opinion*, The Bulletin of the Royal College of Psychiatrists

argue that clinical judgments made without the consent of the patient should be made subject to an independent statutory review. Such a review procedure could also be adopted for treatments which are unusually hazardous, irreversible or not fully established even if the doctor purports to proceed with the consent of the patient.

The competency of detained patients to consent to psychiatric treatment

The fixed distinction relating to the right to refuse treatment based upon legal status contained in the 1959 Act could be justified only by demonstrating that detained patients as a class are incapable of making rational treatment decisions. Indeed, in psychiatry and law the entire edifice of forcible treatment is erected upon the presumed incompetence of patients to consent to medical procedures. Any other position would be arbitrary; if a patient has the capability reasonably to understand the nature and purpose of treatment, there is no more justification for disregarding his own conception of his self interest than there is in the case of any other patient – whether physically or psychiatrically disabled. The rationale of mental health law, then, is that admission status provides sufficient information regarding a person's competency so that further examination of the ability of an individual to comprehend any particular treatment is unnecessary. Informality in the admission process creates a virtually irrefutable presumption of competency throughout hospital residency, while a compulsory status creates the opposite presumption.

The medical and social grounds for the decision to differentiate on the basis of admission status are inadequate for several reasons. First, the medical circumstances necessitating admission are not necessarily the same as those requiring enforced treatment; hospitalisation and legal competence in a variety of contexts are not directly related.⁴ Second, the medical condition of patients on a hospital ward and their competency to make rational treatment decisions do not systematically vary according to legal status. It would be impracticable and inequitable if a valid refusal of an informal patient were

accepted, while the same refusal of an involuntary patient with equal mental faculties were overridden. (Detention itself could not be the conclusive factor for this would cause equal contradiction if the detained psychiatric population were compared to other detained populations who retain the common law right to refuse medical procedures.) Third, unsoundness of mind is usually disabling in limited respects only. Scientific and clinical comparisons of the total range of behaviour exhibited by mentally disordered persons with behaviour exhibited by 'normal' individuals show significant overlap in the two populations. Mentally disordered people are normal in many areas of functioning and for significant periods of time. Even when patients are actively experiencing the symptomatology of a mental illness, much of their behaviour will be normal. Further, during periods where their symptomatology is in remission, their behaviour and cognition are not reliably distinguishable from normal persons.⁵

In respect of competency, then, mentally ill patients – even if validly under detention – are to a significant extent capable of rational thought and behaviour. This is not to suggest that a refusal to receive prescribed treatment cannot sometimes be a product of a patient's distorted cognition or affect. However, this should not be the inevitable presumption of the law. Indeed, patients in large institutions may sometimes experience side-effects and adverse reactions from medication or other treatment before they are adequately observed or heeded by nurses or doctors who may not have the time to listen carefully when faced with excessive caseloads. Respect for a patient's observations about how he feels and how treatment affects him is necessary not merely to safeguard his rights; they are also highly relevant to the medical and social decision to be taken about his welfare.

If it were possible to draw any firm conclusion as to a person's competency solely on the basis of legal status, it would be that an informal status might sometimes indicate a greater lack of understanding than a compulsory status. A patient is admitted informally if he consents to admission or if he is unable

February 1979. This traditional view, however, has been questioned in some quarters. Jacob, *The Right of the Mental Patient to his Psychosis*, 39 MLR 17, 1976; Gostin, *supra*, note 2 at pp 142-48.

4. See Russell-Davis, *Compulsion Under Part IV of the Mental Health Act 1959*, 2 Internat Jol Law and Psychiat 169, 1979; A Stone, *Mental Health and Law: A System in Transition* 68-70, 1975.

5. For a review of the psychiatric literature see Morse, *Crazy Behaviour: Morals and Science: An Analysis of Mental Health Law*, 51 S Cal L Rev 527-77, 1978.

to make a decision. The latter category of patient may be termed 'non-volitional' – *eg* severely mentally handicapped or severely depressed people who are unable to express their will. These patients, because they are classified as informal, are paradoxically presumed to be competent to make treatment decisions. The use of compulsory admission procedures are restricted to those who are volitional and able cogently to state an objection. Here, there is at least a *prima facie* indication of competency, but they may be automatically presumed to be unable to make any decision about psychiatric treatment. This observation is put forward to underline the concept that the law should, wherever possible, avoid rigid outcomes based upon legal status. The simplistic assumption that compulsory admission status can be regarded as an accurate, and the sole, measure of competency in respect of individual treatments is not in accordance with scientific evidence and clinical observations.

Reliability of medical judgments : fact or illusion ?

Legal and medical thought concerning the propriety of allowing mentally ill or mentally handicapped people to exercise judgment in respect of treatment decisions appears to be this. Mental patients are considered to be detained in hospital because they are unable to make reasonably informed judgments concerning the need for treatment. Members of the medical profession are delegated the task of determining those who are lacking competence in this regard and then to substitute their judgment for that of the person concerned. It is the benefit that is said to accrue to the patient which is thought to justify the deprivation of his ordinary right to self-determination. It follows that the law operates on the assumption that psychiatrists can reliably and validly diagnose particular forms of mental disorder, that treatments with reasonably established efficacy exist, and that psychiatrists can make reasonably consistent and objective judgments concerning the need for a treatment response to a particular medical condition. The evidence to support each of these assumptions is highly equivocal.

Diagnoses

One of the most researched areas in psychiatry and social science is the ability of practitioners to make reliable and valid diagnoses of mental illness. Reliability is a term used to describe the frequency of agreement when two or more independent observers answer the same question; that is the ability of psychiatrists to agree upon a diagnosis when viewing the same person or an identical set of symptoms. Research has repeatedly demonstrated that psychiatrists cannot make reliable diagnoses under normal clinical conditions, although refinement of diagnostic skills by experimentally imposed standardisation of interview techniques, nosological nomenclature and psychiatric training tends to improve diagnostic reliability.⁶ Further, a diagnosis often does not convey specific and accurate information about how a patient is currently behaving, why he is behaving in that way or how he is likely to behave in the future. Diagnoses do not appear to be reasonably precise; the same behaviour or affect may be indicative of different diagnoses, while a single diagnosis may incorporate a large range of behaviour and affect. The value of diagnoses, therefore, for the purpose of determining, in a reasonably precise way, legally relevant issues such as compulsory admission, competency and forcible treatment is problematic.

Treatment

There is no conclusive evidence in psychiatry concerning the aetiology of most forms of psychiatric illness, nor is there a clear understanding of why many treatments are thought to have a beneficial effect. Nevertheless, there is some evidence that each of the three major somatic treatments – electroconvulsive therapy,⁷ psychosurgery⁸ and medication⁹ – are empirically effective in the treatment of particular psychiatric conditions.

It has to be observed that the therapeutic effect of each treatment is narrowly limited to particular clinical conditions and depends for its effectiveness on the way it is used. Moreover, use of certain treatments intensively or over long periods of time can result in adverse effects which far outweigh any potential

6. For a review of the voluminous scientific literature on reliability and validity of psychiatric diagnoses see L Gostin, *A Human Condition*, vol 1, 37-52, 1975.
7. See generally, R Palmer (ed) *Electroconvulsive Therapy: An Appraisal*, 1981; Clare, *Therapeutic and Ethical Aspects of Electro-convulsive Therapy: A British Perspective*, 1 *Internat Jol Law and Psychiat* 237, 1978.
8. See generally, Bridges and Bartlett, *Psychosurgery: Yesterday and Today*, 131 *Brit Jol of Psychiatry* 249, 1977; Gostin, *Ethical Considerations of Psychosurgery: The Unhappy Legacy of the Pfe-Frontal Lobotomy*, 6 *J Med Ethics* 149, 1980.
9. See generally, Kennedy, *The Use of Psychiatric Drugs for Decades*, 137 *Brit Jol Psychiat* 387, 1980.

benefit. The principal difficulty in respect of these treatments and the area of disagreement at the interface of medicine and law is as follows. Psychiatrists properly observe that the major somatic treatments can be beneficial and can have acceptable levels of risk. Accordingly, the medical view is that safeguards are not warranted and that decisions about treatment should be left exclusively to the medical profession. The difficulty with this position is the fact that in psychiatry, as in most professions, there is a wide range of competence and expertise as well as limited time and resources with which to take decisions. The consistent findings of the major hospital enquiries in the last decade have shown that treatments are not necessarily limited to interventions with established efficacy and safety, and that the major somatic treatments are sometimes used far too extensively and can result in severe adverse effects for the patient.¹⁰ It should also be observed that psychiatrists have been shown to exhibit a singular style of treatment response and to categorise patients medically in a relatively fixed way which is independent of the symptoms observed. There appears to be an overall predisposition to diagnose psychopathology and a propensity in individual clinicians to diagnose and administer treatment according to their different experience and clinical orientation.¹¹

On what grounds should compulsory treatment be justified ?

In order to justify an independent review of a treatment decision, we would either have to question the wisdom of the doctor in taking the decision or we must point to some specific criteria which are neither medical nor even quasi-medical, but are ultimately non-medical, which makes the doctor the wrong person to apply them. The well-established principle of self-determination in law is that it is improper to impose physical treatment on a competent adult while conscious and cogently expressing an objection.¹² Accordingly, competency and consent should logically be seen to be the foundation of any decision to impose treatment on a patient. These concepts are not medical but essentially lay and legal. The question to be put is

not whether the patient is able to make a more informed and expert medical decision than the doctor, but whether he is able to understand the nature, purpose and risks of the treatment and to express his will rationally. A doctor may well be able to tell us the benefits of a particular treatment, but the decision about whether it is proper to impose it upon an unwilling patient, thus undermining his dignity and physical integrity, is ultimately a social and lay judgment and should not rest on medical grounds alone.

If a psychiatric patient is competent and expressly refuses to consent to treatment, his views should be respected. This is the position in general medicine and, if a psychiatric patient is competent, there are no rational grounds for distinguishing his legal position from that of the physically ill patient. This is not necessarily to suggest that it is in a patient's best interests to refuse treatment, but only that it would be an unjustifiable affront to his human dignity and self-esteem if treatment were to be imposed directly against his express wishes. There can be no greater intrusion on a competent human being than to compel him to receive physical treatment which he does not want.

The parameters of the argument should therefore be placed in perspective. There should be no interference with individual clinical judgment where, in the usual case, there is consent to an established and safe treatment. A measured safeguard is required only where there are strong indications toward the need for closer examination of a proposed treatment. Accordingly, a review procedure would be required where a competent patient was expressly withholding consent. Here, one would expect some form of review which took account of the patient's reasons for refusal.

The concept of 'refusal' is not identical to the lawyers' traditional understanding of the concept of 'consent'. The law ordinarily examines only the issue of whether a person has given an effective legal consent. Failure to demonstrate such a consent is treated identically in law, regardless of the decisiveness of the patient. Thus, it does not appear to

10. S E Thames Regional Health Authority, *Report of the Committee of Enquiry into St Augustines Hospital, Chartham, Canterbury*, 1976; *Report of the Committee of Enquiry into Allegations of Ill-Treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff*, Cmnd 3975, 1969; *Report of Enquiry into Normansfield Hospital*, Cmnd 7357, 1978. See also, *The Report of the Health Service Commissioner* case W 29/74-5, 1977.

11. For a review of the literature see L Gostin, *A Human Condition*, vol 1, 37-52, 1975.

12. For a recent discussion of these issues see, Robertson, *Informed Consent to Medical Treatment*, 97 LQR 102 1981.

matter, for the purposes of the law, whether the patient's response to a proposed treatment is an express refusal or whether, as is more likely, it is indifferent, equivocal, inconsistent, incoherent, inappropriate or entirely absent. In any fresh examination of the law of consent – particularly in psychiatry – there may well be grounds for differentiating among the following categories of response: an effective legal consent, an objection or express withholding of consent, and a non-objection. A non-objection is a situation where a person does not refuse the treatment but where he does not have the desire or understanding to express his will. This is exemplified by the severely depressed or mentally handicapped person who does not, or cannot, respond to a suggestion that a particular treatment should be administered. In such a case, the law might find it appropriate to appoint a guardian or other person who could provide substituted consent.

The only other instance where an independent review would be required is where the treatment was classified as unusually hazardous, irreversible or not fully established. The definitions for these terms are clearly difficult to arrive at.¹³ The term "hazardous" refers to the degree of risk or possible adverse effects of the treatment; there would also be a need to balance this against the potential benefit of the treatment and whether it is regarded as "elective" – *ie* whether other reasonable alternative treatments are available.¹⁴ The phrase "not fully established" refers to the available clinical and empirical evidence which exists to support the treatment, *ie* whether there is reasonable research evidence of its efficacy. It would also refer to the extent to which the treatment is accepted practice within the medical community, but that factor should not be regarded as in any way conclusive. It is intuitively self-evident to a lay observer that if a treatment fulfils one of these conditions, an independent review would be warranted. This would also be the case in respect of irreversible treatments – notably psychosurgery. Thus, if a treatment poses disproportionate risks, does not conform to any medical orthodoxy or irreversibly and significantly affects physiological or psychological functioning, it would be

proper to require the doctor to explain and justify his decision to an independent authority. This proposal does not seek to prohibit the treatment but only to have the decision considered within a wider therapeutic, social and lay context and to give the patient a sense of involvement in the decision-making process.

The question may arise whether there should be a list of special category treatments in a code of practice or statutory instrument which would warrant special safeguards. Research and clinical practice in psychiatry continually alters professional perceptions of particular treatments. Moreover, treatments could not be rigidly classified even if they were subject to periodic review. Specific treatments may be regarded as hazardous or not fully established when used in one clinical context, but not in another. The case of electroconvulsive therapy is illustrative. Electroconvulsive therapy has been shown to be empirically effective in the treatment of severe endogenous depression,¹⁵ although there is some evidence that the electrically induced convulsion is not the critical factor.¹⁶ More importantly, there is no clinical consensus as to its benefit in the treatment of other psychiatric conditions such as schizophrenia and there is no recognised professional body of opinion upholding its use as a method of behaviour control.¹⁷ Electroconvulsive therapy, therefore, may be regarded as fully established in some clinical contexts but not in others.

Electroconvulsive therapy is not normally considered hazardous, except to the extent that any treatment has certain hazards associated with it. It is not unusually hazardous when account is taken of the prospect of benefit to be expected from the treatment in appropriate cases. However, the anaesthetic which precedes ECT may be unusually hazardous to a patient who has just eaten a large meal or who suffers from a heart condition. Electroconvulsive therapy can be hazardous when administered in an unmodified form (*ie* without muscle relaxant and anaesthetic), where there are significant risks of bodily injury,¹⁸ or when it is used intensively or over a long term where there is a risk

13. Definitions for the terms "hazardous", "irreversible" or "not fully established" psychiatric treatments are contained in DHSS, *A Review of the Mental Health Act 1959* 1976; *Review of the Mental Health Act 1959*, Cmnd 7320, 1978. For an analysis of the Government's proposed definitions see Gostin, *supra*, note 2.

14. The term "elective" therapy was discussed in the context of electroconvulsive therapy in *Bolan v Friern Hospital Committee* (1957) 2 All ER 118.

15. Freeman, Basson and Crighton, *Double Blind Controlled Trial of Electroconvulsive Therapy (ECT) and Simulated ECT in Depressive Illness*, 1 *The Lancet* 738-740 1978.

16. Crow *et al*, *The Northwick Park Electroconvulsive Therapy Trial*, 1 *The Lancet* 1317-20, 1980. (This study compared the response rate of two groups of depressed patients. Both groups received a muscle relaxant and anaesthetic but one did not have the electrically induced convulsion. The results showed no significant differences in the effect of the treatment between the experimental and control groups after 4-6 weeks.)

17. Royal College of Psychiatrists, *Memorandum on the Use of Electroconvulsive Therapy*, 131 *Brit J Psychiat* 261-72, 1977. See also Gostin, "A Jurisprudential and Ethical Examination of Electroconvulsive Therapy" in *Electroconvulsive Therapy: An Appraisal*, R Palmer (ed) 1981.

18. Under-Secretary of State for Health and Social Services, *Electroconvulsive Therapy (Broadmoor Hospital)*, in Hansard 744-50, 26th January 1981; Bebbington *et al*, Letter, 1 *The Lancet* 15th March 1980.

of memory deficit and other adverse effects. This argument is applicable to most other treatments; for example, the long term use of anti-psychotic medication carries with it the risk of irreversible neurological damage such as tardive dyskinesia. Accordingly, specific treatments which are used extensively in psychiatry such as ECT or psychotropic medication would not necessarily qualify for the more exacting standard of "hazardous" or "unestablished". Nonetheless, it would be wrong to suggest that they could never qualify regardless of the clinical circumstances or manner in which they were administered.

Consider the example of a consultant who proposes to administer ECT in the treatment of schizophrenia.¹⁹ I specifically choose this example because it is common in large psychiatric hospitals but there is no accepted medical orthodoxy in respect of ECT in the treatment of schizophrenia. The patient may understand the nature and purpose of ECT but refuse to give consent because of his genuine fear of the procedure. One is not making a judgment about the competence or intentions of the doctor's judgment to suggest that ordinarily it would not be right to impose treatment on a genuinely unwilling patient, particularly if there were some uncertainty within the profession as to the prospect of benefit in the particular circumstances. Further, most doctors would not wish to impose the treatment without consent. However, if the doctor did wish to proceed, it would be proper to have some independent safeguard; it would be reasonable to expect him to explain and justify his decision to give ECT, despite the patient's firm objection and in the absence of any clinical consensus as to its benefit.

Similar illustrations could be envisaged with the other major somatic treatments. The standard pre-frontal lobotomy was observed from its earliest use not to be effective in the treatment of schizophrenia. However, it was estimated that some two-thirds of the 10,000 operations conducted between 1942 and 1954 were on patients who suffered from schizophrenia.²⁰ Contemporary psychosurgery is also used in the treatment of schizophrenia despite the fact that rarely is

there any marked clinical improvement.²¹ There is also inconclusive evidence as to the effectiveness of psychosurgery in a number of highly diverse medical and social conditions – for example, psychosurgery has been performed in the cases of anorexia nervosa, sexual deviation, hyper-responsiveness, aggressiveness and anti-social behaviour. Between 1974-76 there were 16 different types of lesions made in a minimum of 14 cerebral sites.²² Despite the multiplicity of existing surgical interventions, together with their use on almost the entire range of psychiatric and social conditions, psychosurgery is not the subject of specific legal or administrative regulation.²³

The effectiveness of the final major somatic treatment – medication with anti-depressive or anti-psychotic effects – is now well established. However, it is also well documented that medication has been used in dangerously high amounts and for excessively long periods in long stay hospital patients. Indeed, the use of major tranquillisers in this way can cause irreparable neurological damage which results in uncontrollable shaking of the limbs and other Parkinsonian-type symptoms.²⁴

The form of review of individual clinical judgment

The form of review of individual clinical judgment more than any other matter divides those who have examined the issue. For the purposes of operating the principles put forward in this paper, the fundamental aspects of a review procedure would be that it is independent of the hospital and the detaining authority; it is multidisciplinary in the sense that it would include a lay element and would not be exclusively or predominantly medical; and it is open and accessible in order to maintain a full sense of patient involvement and to ensure that its procedures and decisions are generally amenable to public scrutiny.

Professional review or audit, represented by second medical opinion or an exclusively or predominantly medical panel, would not be a sufficient safeguard and would not maintain the confidence of the patient. This is on the grounds that issues of competency and

19. See generally, *Hazardous and Irreversible Treatments in Psychiatry – Who Decides?*, SK&F Publications, vol 3 no 6 1980.

20. Tooth and Newton, *Leucotomy in England and Wales 1942-54* in *Reports on Public Health and Medical Subjects*, no 104, 1961.

21. Bridges and Bartlett, *Psychosurgery: Yesterday and Today*, 131 *Brit J Psychiat* 24-60, 1977.

22. Barraclough & Mitchell-Heggs, *Use of Neurosurgery for Psychological Disorder in the British Isles during 1974-76*, 2 *Brit Med J* 1591-93, 1978.

23. Gostin, *Ethical Considerations of Psychosurgery: The Unhappy Legacy of the Pre-Frontal Lobotomy*, 6 *J Med Ethics* 149-54, 1980.

24. Kennedy, *The Use of Psychiatric Drugs for Decades*, 137 *Brit J Psychiat* 387-89, 1980.

consent cannot be determined solely on the basis of medical or scientific expertise but require a lay, social and commonsense judgment. The decision to impose a treatment on an unwilling patient requires a subjective choice among a number of diverse values including the purpose and importance of the treatment, possible adverse effects and the strength and cogency of the patient's reasons for refusal. That choice and balancing of values lies outside the exclusive competence of a single doctor and can only partly be the concern of the medical profession.

An additional factor is the understandable reluctance within the medical profession (or, for that matter, within most professions) to interfere with the judgment of a colleague who is responsible for a case. Individual clinical judgment or clinical autonomy is an important part of the thought and training of medicine; a doctor who is not directly responsible for a patient would be faced with formidable professional restraints if he had openly and directly to contradict a colleague, particularly where his second opinion would take precedence over the opinion of the responsible consultant. This form of peer review would be particularly unacceptable if it permitted the doctor to choose a colleague from whom he would seek a concurring opinion. One would expect the doctor to choose an individual with similar clinical orientation, training and experience and there would be considerable informal pressure toward conformity where the two doctors had to maintain a continuing professional relationship. There would also be questions raised as to whether the doctor could 'canvas' opinion — *ie* seek a second or third opinion if the first did not concur.

Some of these reservations may be partly illusory. However, exclusive professional self-regulation is always open to the criticism that it is not sufficiently energetic or dispassionate, that there may be informal pressures to protect a fellow member of the profession and that the views of questioning non-professionals may not be given sufficient weight. Confidence of the patient and public would be maintained only by independent examination and review of individual clinical judgment.

In devising a properly constituted second opinion, it is important to avoid, wherever possible, cumbersome, expensive or time-consuming machinery. For this purpose, it may be preferable if the second opinion were associated with a currently existing institutional structure. Mental health review tribunals or independent hospital ethical committees are not currently used for evaluating clinical treatments. (Mental health review tribunals are empowered to examine issues of discharge but not treatment and hospital ethical committees evaluate the clinical and ethical aspects of medical research.) Nonetheless, consideration may be given to adapting such institutional structures for use in this context. The use of mental health review tribunals particularly commends itself because they have existing panels of legal, medical and lay members, they are at present substantially under-used and there is a government proposal to increase the size of the tribunal by adding a social work member.²⁵

Conclusion

There is an unquestioning acceptance among many legislators, lawyers and doctors that judgments concerning a patient's body may validly be removed from the individual and delegated to experts in the psychiatric, but not the general medical, context. The assumptions are that a person is detained because he is incompetent to make any treatment decision; that the doctor can make reasonably reliable and objective judgments concerning diagnosis and treatment; and that the benefit the patient would accrue from forcible treatment would outweigh any interest he may have in self determination. It has been the burden of this paper to illustrate that these assumptions are automatic responses to involuntary admission to hospital which are supported more by intuition than by scientific fact or jurisprudential thought. There is an intuitive medico-legal disposition to hold a psychiatric patient incompetent, irrespective of his clinical condition or capacity for specific rational understanding. This is suggested by a number of factors including the status of the patient as involuntary, the doctor's primary, statutory and moral responsibility to detain and treat the patient rather than to respect his refusal

25. See, L Gostin and E Rassaby, *Representing the Mentally Ill and Handicapped: A Guide to Mental Health Review Tribunals*, 1981.

of a treatment which the doctor believes to be medically indicated, and the natural presumption by those who regard themselves as mentally healthy (particularly if they are endowed with specialist knowledge) that they have greater understanding than the mentally infirm. All of these factors may instigate towards paternalism and a pre-determination of a patient's competency. Any difference of opinion may be regarded as a question of who is qualified to make a decision. It is within this context that a patient's refusal to consent may be seen, not as a statement of will, but as a symptom of unsoundness of mind. The colloquialisms "doctor knows best", "you really don't mean that" and "you will thank me later" have become the unwritten rules within which the merits of a patient's consent are assessed.

Ethically, a patient should be free to make a decision which may be against his medical interests so long as he is able to understand the implication of that decision; the common law places no legal obstacle to a patient's decision to live in great pain or even to risk his life rather than to accept unwanted medical treatment. The fundamental issue, however, is who should ultimately decide whether the patient is capable of understanding and whether the treatment should be imposed against his wishes. I have suggested that the doctor — one of the partners in the therapeutic trans-

action — should not make the final judgment; nor should the decision be subject solely to professional self-regulation. This was intended, not to impugn either the expertise or integrity of the doctor, but to show the importance, from the perspective of the patient and the lay public, of introducing a decision-making process which is independent and in which he could have confidence.

It is, of course, fundamental to the therapeutic relationship that the patient who enters hospital for treatment has trust in the doctor and does not refuse all forms of treatment. The law, moreover, should not normally interfere in a doctor-patient relationship if it is based upon trust and consensual agreement. However, once that trust breaks down, a psychiatric patient, unlike physically ill patients, will find it difficult or impossible to choose another doctor or simply to leave the hospital; the detained psychiatric patient also has limited access to his general practitioner or to a second medical opinion if he disagrees with a particular form of treatment. It would be wrong in these circumstances if he were compelled in law to accept *any* treatment proposed and where, if he disagreed for whatever reason, his only recourse was to the same doctor who originally recommended the treatment.